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A Consumer's Eye View of Family-Involved Alcohol Treatment

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Introduction

There is consistent evidence that family involvement helps engage treatment-resistant individuals with substance use disorders (SUDs) into therapy (Manuel et al., 2012; Miller, Meyers, & Tonigan, 1999), enhances the probability that adults in detoxification units later enter formal treatment (Ino & Hayasida, 2000; O'Farrell, Murphy, Alter, & Fals-Stewart, 2008), and improves outcomes across a range of populations (McCrady, Epstein, Cook, Jensen, & Hildebrandt, 2009; McCrady et al., 1986; O'Farrell, Choquette, & Cutter, 1998; O'Farrell, Schumm, Dunlap, Murphy, & Muchowski, 2016; Powers, Vedel, & Emmelkamp, 2008; Schumm, O'Farrell, Kahler, Murphy, & Muchowski, 2014). Approaches with promising efficacy data include family-based contingency management to enhance adherence to aftercare (Ossip-Klein & Rychtarik, 1993) or medication (Azrin, Sisson, Meyers, & Godley, 1982), behavioral couple therapy (BCT) for SUDs (e.g., Powers et al., 2008), Community Reinforcement and Family Training (CRAFT; Miller, Meyers, & Tonigan, 1999), a Relational Intervention Sequence for Engagement (ARISE; Garrett et al., 1998), brief family therapy to facilitate treatment engagement after detoxification (O'Farrell et al., 2008), and the Brief Discharge Intervention Method (Ino & Hayasida, 2000).

Families contribute to successful change in an alcohol use disorder (AUD) by enhancing problem recognition, motivating a person to seek help, supporting treatment involvement, and/or supporting long-term change (McCrady, 2004). Research on Alcohol Behavior Couple Therapy (ABCT) examining pre-to post-treatment behavior change has suggested that partners learn skills to reinforce abstinence (e.g., O'Farrell & Fals-Stewart, 2000), and that partner reinforcement of abstinence is associated with better outcomes. Some research also has suggested that ABCT results in increased relationship satisfaction in couples (e.g.,

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McCrary, Stout, Noel, Abrams, & Nelson, 1991), that there is a positive association between dyad behaviors and drinking outcomes (McCrary, Hayaki, Epstein, & Hirsch, 2002), and that improved relationship functioning leads to improvements in drinking (O'Farrell et al., 2008). Across studies, results have identified three core active ingredients in family-involved treatment: (a) increasing family support for behavior change, (b) increasing positive exchanges and decreasing negative exchanges in the family (Walitzer, Derman, Shyhalla, & Kubiak, 2013), and (c) improving communication. These active ingredients are hypothesized to increase treatment adherence, commitment to abstinence, perceived family support, positive exchanges in the family, and positive communication.

Underutilization and Barriers to Use of Couple/Family Treatment

Although national surveys suggest that 80% of SUD treatment programs provide some type of family involvement in treatment (Forcehimes et al., 2010), very little of this treatment is evidence-based (Schonbrun et al., 2012). In fact, even after receiving specific training in an empirically-supported family treatment, ABCT, a minority of clinicians (22.2%) reported using the treatment 14 months later (Houck, Forcehimes, Davis, & Bogenschutz, 2016). It has been suggested that empirically-supported alcohol treatments generally have not been adopted by community treatment providers because researchers have focused on efficacy trials that test treatments under controlled conditions with select populations, and have not focused on dissemination. Specific barriers to the use of evidence-based, family-involved alcohol treatment appear to include: (a) the *length and complexity* of empirically-supported family therapies (Haug, Shopshire, Tajima, Gruber, & Guydish, 2008); (b) *patient and family* factors such as patient reluctance to have their families involved, family concerns about feeling blamed or responsible for the patient's treatment, and pragmatic issues related to scheduling (McCrary, Epstein, Cook, Jensen, & Ladd, 2011); (c) *clinician* barriers such as disagreements with the models underlying evidence-based approaches, viewing the findings from controlled trials as having limited applicability to their on-going clinical work (Houck et al., 2016), lack of appropriate training, and the perceived complexity of couple and family therapies (e.g., Haug et al., 2008); and (d) *institutional* barriers such as difficulties with third-party reimbursement for family treatment sessions. Efforts to disseminate empirically-supported family treatments for AUD, adapt these treatments to focus on core active ingredients of the treatments, or develop models that can easily be integrated into on-going AUD treatment have been very limited.

Despite the fact that empirically-supported family treatments for SUDs have not been disseminated widely, models to better guide dissemination do exist. For example, McHugh and Barlow (2010) reviewed successful large-scale efforts to disseminate empirically-supported treatments and identified several common elements, including: (a) needs and barriers assessment; (b) training structure; (c) didactic training; (d) competence training; (e) outcomes evaluation; and (f) sustainability models (e.g., training of trainers). Given the underutilization of empirically-supported family-involved treatment in front-line AUD treatment programs, and lack of previous research focused specifically on building a family treatment with the potential for large-scale dissemination, a key first step we identified was the importance of a needs and barriers assessment. We conducted this needs and barriers assessment using a focus group approach.

Focus groups have long been a tool of marketing agencies, but more recently researchers in the social sciences have begun to tap the potential of interviewing participants using focus group methodology. Focus groups may be of particular value when historically underrepresented populations are of interest; information gleaned in this style can afford an important voice to participants not usually accessible by researchers. Moreover, the interview-style format of focus groups can be inclusive of individuals of varying levels of literacy or for whom English is a second language. Having an opportunity to speak directly to research staff and voice perspectives and opinions can be empowering for members of underrepresented and underserved populations (Liamputtong, 2010).

The overall aim of the current study was to use focus groups and qualitative methods to learn more about consumer perspectives (patients, families, and clinicians) on the interactions between persons with AUDs and their families as well as the role of the family in AUD treatment to help inform the development of a family treatment model with greater potential for uptake in community AUD treatment programs. The focus groups were part of a larger NIH funded study investigating the development and implementation of a brief, family-involved treatment. Using a qualitative analysis of focus group data, the specific aims were to identify: (a) key consumer concerns about the impact of AUD on families; (b) consumer perspectives on barriers to family-involved treatment; and (c) consumer perspectives on strategies to increase the adoption of family-involved treatment. The focus groups also were used to obtain feedback on a preliminary draft of the planned family-involved treatment manuals and materials, which were derived from ABCT (McCrady & Epstein, 2009), but designed as a three session intervention for the NIH treatment development study.

Materials and Methods

Participants

To gain diverse feedback, four focus groups were conducted with a total of 25 participants:

Patient group.—Patients were recruited via flyers in the waiting room of a community SUD treatment clinic. Inclusion criteria required that patients were receiving treatment for a drinking problem, interested in participating in a focus group, able to speak English, and at least 18 years of age. The recruited sample ($n = 6$) was 33% female with a mean age of 46 and an average education level of 14 years (two years of college). Fifty percent of the sample identified as Hispanic, 33.3% identified as non-Hispanic White, and 16.7% identified as Asian-American.

Family member group.—Family members of patients being seen in the clinic also were recruited via flyers in the clinic waiting room, as well as through invitations from patients and clinicians. Inclusion criteria required that they have a family member receiving alcohol treatment, that they were interested in participating, able to speak English, and at least 18 years of age. The family member sample ($n = 4$) was 75% female with a mean age of 53.5 and an average education level of 15 years (three years of college). Seventy-five percent of the sample identified as Hispanic, and 25 % identified as non-Hispanic White. Most (75%) of the sample were spouses of patients; one family member (25%) was a parent.

Clinician group.—Clinicians were recruited from a local SUD treatment program, with the approval of the clinic’s director. Inclusion criteria required that they were treating patients at the clinic, able to speak English, and interested in participating in a focus group. The recruited sample consisted of 15 clinicians. Their demographic information was not collected in order to preserve their anonymity.

Procedures

Focus groups were planned and run using guidelines published by the Center for Disease Control and Prevention (2008). Four sets of prompts were tailored for the groups (see Table 1) and contained questions such as: “What is your relationship to the family member who is receiving services at [treatment agency]?” and “What challenges has your drinking caused for your family?” Differing somewhat from the parallel structure of the patient and family groups was the clinician group, as that group was designed to elicit feedback from professionals about the feasibility and complexities of involving family members in treatment. Clinicians were asked questions such as: “What clinical barriers are there to involving family members in treatment?” Facilitators also showed focus group members some materials from the draft treatment manual to obtain their feedback. The treatment manual was cognitive-behavioral in focus, and initially included several topics: (a) rationale for family involvement; (b) increasing shared activities; (c) improving communication; and (d) behavioral contracting to reinforce treatment/recovery-relevant behaviors. Because this feedback was very specific to the treatment materials, we did not code responses, but did use the feedback to modify aspects of the treatment manual and handouts.

Each focus group was facilitated by two members of the research staff, including the principal investigator (PI) and four graduate students. The clinician group was facilitated by the PI and one pre-master’s graduate student. One family group was facilitated by a master’s level graduate student and the PI; the second family group was co-facilitated by two master’s level graduate students. The patient group was co-facilitated by one master’s level and one pre-master’s graduate student. All groups started with an ice-breaker and introductions, orientation of participants to the basic structure of the group, and guidelines around confidentiality and creating a respectful space for discussion.

All groups were audio recorded. Participants were oriented to the purpose of recording the sessions, and given the opportunity to voice concerns and ask questions prior to commencing recording. After the groups concluded, the audio recordings were transferred to a secure, password-protected server, and deleted from the original recording device. Only study staff had access to the recordings. Once the audio recordings were coded for content and analyzed, the information was used to modify and finalize the study materials to pilot test the new family-involved treatment.

Measures

Coding system.—The system used to code the patient, family member, and clinician focus groups was developed following the approach articulated in the Grounded Theory Approach to analyzing qualitative data (Corbin & Strauss, 1990; Glaser & Strauss, 1967; Strauss & Corbin, 1994). The Grounded Theory Approach uses constant comparative

analysis or the constant comparative method in which the researcher moves in and out of data collection and data analysis in an iterative fashion. The first step under Grounded Theory employed in the present study was theoretical sampling of constructs from the audio-recorded focus groups.

Three study researchers listened to all of the focus group recordings and engaged in the process of open coding by dividing the data into preliminary groupings of theoretically similar themes and categories. Using this preliminary coding system, four research team members then each coded one of the focus group recordings to further refine the themes and categories identified in the initial open coding process. Upon completion of the open coding, the entire research team engaged in axial coding by reviewing the preliminary coding of each focus group, and combined redundant coding themes and categories. The recordings were then once again coded using the coding system resulting from the axial coding. The four research team members who had each previously coded a focus group audio recording then recoded an audio recording not previously coded by that particular researcher. After the recordings had been double-coded, the entire research team once again came together to engage in selective coding to address any coder disagreement by organizing and integrating the themes, and reached saturation in the coding system. The final coding system resulting from this process is presented here.

Coding software.—Coding of the audio recordings was completed using the Simple Video Coder (SVC; Barto, Bird, Hamilton, & Fink, 2016), a free, open-source software program for coding behavioral data. SVC was developed specifically for the coding of video-recorded behavioral data. To account for this, audio recordings of the focus groups were converted to video files (.avi) and uploaded into the SVC for coding with the system developed for this project.

The SVC produces two human-readable output data (.csv) files that allow for easy comparison between coders. The first file contains the codes generated by the coder, and the second contains the file name, file location, date of coding, participant identification number, and all of the codes generated in sequential order. These files were used throughout the process of open coding, axial coding, and in integrating themes. Table 2 lists all codes.

Results

Responses were ranked separately for each group of respondents (patients, families, clinicians) from the most to the least frequently coded. All codes and frequencies are listed in Table 2. Here, we report the most frequent codes, with accompanying quotes to illustrate the impact of AUD on families, barriers to attending family-involved treatment sessions, and strategies to increase adoption of family-involved treatment.

Key Consumer Concerns about Impact of AUD on Families

A wide range of concerns were expressed about the impact of AUD on families.

Patient focus group.—The most commonly expressed concerns about the impact of the AUD on their families in the patient focus group included: (a) disruption their AUD had

caused to their family relationships (Disrupted Family Relationships, frequency: 10); (b) negative interpersonal interactions (Negative Interpersonal Impact, frequency: 7); and (c) drain on family resources (Resource Drain, frequency: 5). Illustrative comments from patients expressing these concerns included:

“The craziness of [my family] not knowing where I’ve been, for two weeks at a time, things like that.” (Disrupted Family Relationships).

“I would get into arguments with her, like, don’t tell me what to do, I’m a legal adult, I can do what I want to.” (Negative Interpersonal Impact).

“I went through all the resources that I had, so now, my dad is paying my rent, so that’s really a bummer for me, because they are older, older adults...having to help [me] out.” (Drained Resources).

Family focus group.—Family members in the family focus groups described similar effects on the family as did the patients, including (a) negative interpersonal interactions (Negative Interpersonal Impact, frequency: 22); (b) drain on family resources (Resource Drain, frequency: 5); and (c) inconvenience to the family (Inconvenience, frequency: 5). Quotes from family members that illustrate these concerns included:

“She has this tendency to be verbally abusive, plus, even with pushing me around and stuff like that.” (Negative Interpersonal Impact).

“In the last two years, my ex-husband and I have spent at least \$10,000...programs, rehabs through the city, bonding her out when she’s been drinking.” (Resources Drain).

“I have to come all the way over here and bring her, and that’s the problem I’m having, dealing with somebody that, how do we handle this, as a parent?” (Inconvenience).

Clinician focus group.—Key concerns arising from the clinician focus group were similar to those the patients and family members expressed, and included: (a) the disruption to family relationships as result of the patients’ AUDs (Disrupted Family Relationships, frequency: 4); and (b) negative interpersonal interactions (Negative Interpersonal Impact, frequency: 1). Quotes from clinicians that illustrate these concerns included:

“They have to go through a process of beginning to start to speak to people again, and sometimes it’s been years...so really it’s a long term process and it usually doesn’t happen in the first few months of treatment.” (Disrupted Family Relationships).

“We see a client who is really working on their sobriety, and the family member, coming from a place of fear, and for them the change isn’t fast enough, so, four months in, we’re saying ‘Boy, they only had three episodes of drinking, and the family member is saying ‘But they’re still drinking!’ , so part of it is the different way of looking at the progress they’re making.” (Negative Interpersonal Impact).

Consumer Perspectives on Barriers to Family-Involved Treatment

Different perspectives emerged around perceived barriers to treatment.

Patient focus group.—Commonly endorsed perceived barriers to treatment in the patient focus group included: (a) pragmatic or logistical challenges to family treatment (Pragmatic Challenges, frequency: 3); (b) patient ambivalence (Patient Ambivalence, frequency: 3); (c) avoidance around the subject of drinking (Avoid Discussing Drinking, frequency: 2); and (d) impact on self-concept (Impact on Self Concept, frequency: 2). Illustrative comments from patients expressing these concerns included:

“I always live in a different city from them, so they can’t really help me out.” (Pragmatic Challenges).

“I’m just saying, I wouldn’t want to do it now, at this point in my life, having been an alcoholic for 35 years.” (Patient Ambivalence).

“It’s just a waste of my time, so I don’t even try to tell them anything about what’s going on in my life...they want to hear what (I’m) watching on TV, neutral dumb subjects.” (Avoid Discussing Drinking).

“As an alcoholic I’m a good con artist, as a drug addict, I’m a good con artist, whether I want to admit it or not. If I went to my family, I could either talk them into it, or talk them out of it. It would totally be on my part, because I could go ‘You know what, I really need you there, it’s something that is going to help my recovery’...and, would I tell them that?” (Impact on Self-Concept).

Family focus group.—Barriers to treatment endorsed in the family member focus groups included: (a) relational barriers (Relational Barriers, frequency: 2); (b) family member ambivalence (Family Ambivalence, frequency: 1); (c) impact on self concept (Impact on Self Concept, frequency: 1); and (d) avoidance of discussions about drinking (Avoid Discussing Drinking, frequency: 1). Illustrative comments from patients expressing these concerns included:

“I can tell her very juvenile delinquent type of friends are dragging her down, and it really is sort of tough to say, ‘All right, why don’t we just go home now,’ especially when she wants to stay out.” (Relational Barriers).

“If something happened five years ago... and that gets raised in these sessions, then it becomes more family counseling and not just treating the alcohol.” (Family Ambivalence).

“And you don’t want them to think that, ok, if they stay with me, it will be a responsible time, but if they go out with their friends it will be a fun time.” (Impact on Self-Concept).

“I don’t want the confrontation. So it’s easier to go along than to have a big to-do.” (Avoid Discussing Drinking).

Clinician focus group.—Barriers to treatment endorsed in the clinician focus group included: (a) pragmatic challenges (Pragmatic Challenges, frequency: 8); (b) institutional barriers (Perceived Institutional Barriers, frequency: 5); (c) family member ambivalence (Family Ambivalence, frequency: 3); and (d) familial support for drinking (Family Supporting Drinking, frequency: 3). Quotes from clinicians that illustrate these concerns included:

“Billing, probably...yeah, billing. And scheduling, getting a time when both can come together.” (Pragmatic Challenges).

“I would also think the confidentiality of the family member coming to the session, where their history might appear in our notes on our client...because technically the family member is not our client.” (Perceived Institutional Barriers).

“I think a lot of times people think we’re going to do some kind of empty chair thing or there’s going to be some big discussion about every past transgression that has ever occurred.” (Family Ambivalence).

“I’m dealing with some families that are really sabotaging treatment, because they don’t want to get behind the whole treatment process, they don’t understand it. I’m not sure what’s motivating them, but they withhold transportation, they will make other arrangements, family obligations, and guilt people out of coming to therapy...It’s almost as if they want that individual to stay ill, so that they can continue to be the rescuer.” (Family Supporting Drinking).

Consumer Perspectives on Factors to Increase Utilization of Family-Involved Treatment

A number of factors that may increase the utilization of family-involved treatment were suggested in the focus groups.

Patient focus group.—Factors to increase utilization of family-involved treatment described in the patient focus group included: (a) positive interpersonal impact (Positive Interpersonal, frequency: 6); (b) accountability (Accountability, frequency: 4); and (c) involvement of a sibling (Sibling, frequency: 3). Quotes from patients that illustrate these factors included:

“My mom, she asks all the time. She asks how my treatment is going, Am I doing fine, am I doing well, so, there’s no problems with that, she’s very supportive.” (Positive Interpersonal Impact).

“My mom is just concerned that if I do drink, then I’m not allowed to call her. Like if I’m high, she just says ‘Do not call me. Call me when you’re sober, and whatever it is, we can talk about it then.’” (Accountability).

“My sister...I would love to have her over there to understand what I’m going through.” (Sibling).

Family focus group.—Factors to increase utilization of family-involved treatment endorsed in the family focus groups included: (a) positive interpersonal impact (Positive Interpersonal Impact, frequency: 6); b) optimism about family attendance (Optimism re Family Attendance, frequency: 4); and (c) expert recommendation for treatment (Expert Recommend Treatment, frequency: 3). Quotes from family members that illustrate these factors included:

“When she came home, you’d kind of at least want to talk about it, let them know that you’re there for them, and if they want to open up and talk about it that’s fine.” (Positive Interpersonal Impact).

“I’d go. She already knows that...whatever works, to help her, I would do.” (Optimism re Family Attendance).

“If in that first session the counselor suggested, or directed her to bring me.” (Expert Recommend Treatment)

Clinician focus group.—Factors to increase adoption of family-involved treatment endorsed in the clinician focus group included: (a) positive interpersonal impact (Positive Interpersonal Impact, frequency: 4); (b) optimism about family attendance (Optimism re Family Attendance, frequency: 3); and (c) expert recommendation for treatment (Expert Recommend Treatment, frequency: 3). Quotes from clinicians that illustrate these factors included:

“I think these are some really focused activities that address some core issues... communication skills is key, and doing the positive activities together also changes your lifestyle, which we tell our clients all the time, it’s important to change your lifestyle.” (Positive Interpersonal Impact).

“A lot of times they will want to bring another family member to create change for themselves, maybe getting out of a situation with a partner who uses, so they’ll bring a dad, or someone who can be helpful in making that change.” (Optimism re Family Attendance).

“Mostly inviting the client to bring in a family member who has questions: ‘You’re welcome to bring them to the next session’ or something to that effect.” (Expert Recommend Treatment).

Feedback on Treatment Materials

Feedback on the proposed treatment materials was generally positive. Patients, some of whom were involved with 12-step programs, thought there should be some information about 12-step recovery, or at least an introduction to a biopsychosocial and spiritual model of addictions. Clinicians thought that patients might be concerned about being “beaten up” when the family member came to treatment, and stressed the importance of a present focus for the sessions, as well as providing some explanation for families on the etiology of SUDs and the process of recovery. Family members talked about the impact of the SUD on the children of the patients, and thought that some acknowledgment of the children should be included in the sessions. All groups noted that the activities listed in the shared activities

handout seemed geared to middle-class households, and encouraged the inclusion of more low cost or free activities.

Discussion

Although there is a large body of research documenting the incremental benefit of using evidence-based family treatments for AUDs, adoption of evidence-based family treatment in front-line treatment agencies has been extremely limited (Schonbrun et al., 2012). The overall aim of the current study was to use focus groups and qualitative methods to learn more about consumer perspective (patients, families, and clinicians) on the interactions between persons with AUDs and their families and the role that families might play in AUD treatment, and to use these perspectives to inform the development of a family treatment model with greater potential for uptake in community AUD treatment programs. Focus groups were used as a vehicle to allow the relatively unconstrained expression of consumers' perspectives.

Several key themes emerged from the focus groups. First, patients, family members, and clinicians all were acutely aware of the substantial disruption to family relationships that the AUD had caused. Similarly, patients and families were concerned about the very negative interactions they had with each other and the impact of the AUD on financial and other family resources. Second, all groups saw barriers to family-involved treatment, even though they thought it would likely be helpful and worthwhile. Patient and family ambivalence were seen as important barriers by all groups. Interestingly, both patients and family members wanted family involvement, but were concerned that the other party would not be interested. Barriers also included the pragmatic challenges of scheduling and transportation. Clinicians also were acutely aware of institutional barriers that made it difficult for them to engage families in the treatment, such as billing for family-involved sessions and the confidentiality of the family member as it pertains to documentation in electronic health records.

Specific strategies to overcome perceived barriers and improve utilization of family-involved treatment were suggested or implied. First, all groups focused on the value of positive interactions between the person with the AUD and other family members. Key to this perspective is the importance of including constructive, positive interventions in any family-involved treatment, and communicating to patients and family members that building positive interactions will be an important treatment element. Although building positive interactions is an integral element of most family therapies, such an approach was seen as particularly important, given both the ambivalence of patients and family members, and the fear that bringing a family member into the session would lead to the family member expressing anger and past hurts. Communicating to patients that the positive focus is integral to the sessions may enable them to be more receptive to family involvement. A second theme that emerged was the role of the clinician in initiating family involvement. In the patient focus group, several participants expressed a desire to have a family member join them in treatment, but expressed concern that the family member might not want to come. Participants in the family groups expressed similar concerns – they wanted to participate but were not sure the patient would want them to attend. A solution suggested by both the patient and family groups was for clinicians to take an active role in bringing the two

together; the clinician could initiate the discussion about family involvement with an optimistic expectation that a family member would like to participate, and that family participation would be positive and constructive.

There are limitations to the current study that may affect the generalizability of these findings, such as the inclusion of clinicians from only one treatment program and a small sample size. A review of the literature suggests that qualitative studies typically reach thematic saturation with a sample of 9–12 participants (e.g., Guest, Bunce, & Johnson, 2006; Hennink, Kaiser, & Marconi, 2017). Given that we used one codebook to code all of the focus groups, our sample of 25 should be sufficient to identify key themes. The study also has several key strengths. For example, the study was unique in gathering the perspectives of patients, families, and clinicians about family-involved treatment for AUDs. The sample was also diverse in ethnicity, age, and sex. Lastly, the use of established methods of coding the focus groups to obtain common themes and better understand their concerns was also a strength of the study.

Conclusions

We are hopeful that following the outline of McHugh and Barlow (2010) about conducting a needs and barriers assessment as part of deliberately building a family-involved treatment will lead to a treatment that will be more broadly disseminated and adopted than existing models of family-involved treatments. In addition to incorporating stakeholders' perspectives into the treatment itself, we also solicited input from stakeholders on drafts of treatment materials. Their feedback contributed to the modification of these materials, which are being pilot tested. Also, following Epstein et al.'s (2007) successive cohort design for the development of a new treatment, a second round of focus groups will be used to solicit additional input to further refine the treatment. Each succeeding step in the treatment development will focus on creating simplified and easily exportable training structures and materials, and outcomes evaluation with clinicians in front-line treatment programs. We anticipate that these efforts will increase the adoption of this family-involved treatment in a manner that is commensurate with the established efficacy of these treatment models.

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Table 1.

Questions Asked of Focus Group Participants

Question	Patient	Family	Clinician
Concerns About Family Involvement In Treatment	What challenges has your drinking created for your family?	What challenges has your loved one's drinking created for your family?	
	What challenges has your treatment created for your family?		
	What are your biggest concerns about how your family responds to your drinking?	What are your biggest concerns about how to respond to your loved one's drinking?	What major concerns do you hear from patients about their families?
			What major concerns do you hear from family members about the patients?
Barriers to Treatment	How likely do you think it is that they would come [to treatment]?	How likely do you think you would be to come [to treatment]?	What programmatic barriers are there to involving family members in treatment?
	What would help them decide to come [to treatment]?	What would help you decide to come [to treatment]?	What clinical barriers are there to involving family members in treatment?
Factors that Decrease Barriers to Treatment	How do you think your family could be most helpful to you in not drinking?	How do you think you could be most helpful to your loved one in not drinking?	What strategies have you found helpful in engaging family members in treatment?
	What would you think of having a family member participate in your treatment through a few sessions with one of the counselors?	What would you think of participating in your loved one's treatment through a few sessions with one of the counselors?	
	What family member would you most like to have involved?		

Table 2.

Coded Focus Group Responses – Patients, Families, Clinicians

	Patients Frequency (%)	Family Frequency (%)	Clinicians Frequency (%)	Totals Frequency (%)
Concerns re Impact on Family				
Negative Interpersonal Impact	7 (11.2)	22 (33.8)	1 (02.6)	30 (18.1)
Disrupted Family Relationships	10 (16.1)	3 (04.6)	4 (10.3)	17 (10.2)
Resource Drain	5 (08.1)	5 (07.7)	0 (00.0)	10 (06.0)
Inconvenience	3 (04.8)	5 (07.7)	0 (00.0)	8 (04.8)
Emotional Impact	0 (00.0)	3 (04.6)	0 (00.0)	3 (01.8)
Impact on Children	0 (00.0)	3 (04.6)	0 (00.0)	3 (01.8)
Attempts to Control Drinking	0 (00.0)	3 (04.6)	0 (00.0)	3 (01.8)
Legal Problems	2 (03.2)	0 (00.0)	0 (00.0)	2 (01.2)
Setting Boundaries/Self-Care	0 (00.0)	1 (01.5)	0 (00.0)	1 (00.6)
Barriers to Treatment				
Pragmatic Challenges	3 (04.8)	0 (00.0)	8 (20.5)	11 (06.6)
Relational Barriers	0 (00.0)	2 (03.1)	0 (00.0)	2 (01.2)
Family Ambivalence	1 (01.6)	1 (01.5)	3 (07.7)	5 (03.0)
Patient Ambivalence	3 (04.8)	0 (00.0)	2 (05.1)	5 (03.0)
Perceived Institutional Barriers	0 (00.0)	0 (00.0)	5 (12.8)	5 (03.0)
Impact on Self Concept	2 (03.2)	1 (01.5)	2 (05.1)	5 (03.0)
Avoid Discussing Drinking	2 (03.2)	1 (01.5)	0 (00.0)	3 (01.8)
Family Supporting Drinking	0 (00.0)	0 (00.0)	3 (07.7)	3 (01.8)
Pessimism re Family Attendance	1 (01.6)	0 (00.0)	1 (02.6)	2 (01.2)
Factors to Increase Use of Family-Involved Treatment				
<i>Family Factors</i>				
Positive Interpersonal Impact	6 (09.7)	6 (09.2)	4 (10.3)	16 (09.6)
Optimism re Family Attendance	2 (03.2)	4 (06.2)	3 (07.7)	9 (05.4)
Accountability	4 (06.5)	0 (00.0)	0 (00.0)	4 (02.4)
Benefits to Family	2 (03.2)	0 (00.0)	0 (00.0)	2 (01.2)
<i>Preferred family member</i>				
Child	2 (03.2)	2 (03.1)	0 (00.0)	4 (02.4)

	Patients Frequency (%)	Family Frequency (%)	Clinicians Frequency (%)	Totals Frequency (%)
Sibling	3 (04.8)	0 (00.0)	0 (00.0)	3 (01.8)
Combination of Family Members	1 (01.6)	0 (00.0)	0 (00.0)	1 (00.6)
Least Judgmental Family Member	1 (01.6)	0 (00.0)	0 (00.0)	1 (00.6)
<i>Other</i>				
Expert Recommend Treatment	2 (03.2)	3 (04.6)	3 (07.7)	8 (04.8)
Totals	62 (100)	65 (100)	39 (100)	166 (100)